should be less than the current rate the Department will assign the lower rate for that component to the nursing facility.

80.6.3 The reimbursement rates set, as stated in Sections 80.6.1 and 80.6.2, will remain in effect for the period of three (3) years from the date that they are set under these Principles.

80.6.4 At the conclusion of the three years, the reimbursement rate will be rebased to the fiscal year stated in Sections 41.3.1 and 43 or the most recent audited fiscal year occurring after the opening of the new facility, the completion of the new renovation, or the sale of the facility, whichever is the most current.

80.6.5 For the first, second, and third rate setting period, the base year case mix index that will be used for the prospective rate calculation will be 1.000. Similarly, the quarterly case mix index will be set at 1.000. For the fourth rate setting period, the base year index will be calculated based on all the nursing facility's Medicaid resident's average case mix indexes excluding the not classified group as of the 15th of the fourth month after the fiscal year begin date of the pro forma cost report. For example, if a facility's fiscal year beginning was January 1, 2001, the base year index would be calculated using all Medicaid residents with classifiable assessments as of April 15, 2001. The quarterly rate setting index would then be set as specified in Section 80.3.4.

80.7 NURSING HOME CONVERSIONS

80.71 In reference to Public Law 1981, c. 705, Pt. V, § 304, the following guidelines have been established in relation to how nursing facilities that convert nursing facility beds to residential care beds will be reimbursed:

80.71.1 A proforma step down cost report for the year in which the bed conversion will take place or the first full fiscal year in which the facility will operate with both nursing facility and residential care facility levels of care will be submitted to the Bureau of Elder and Adult Services and to the Division of Reimbursement and Financial Services of the Bureau of Medical Services.

80.71.2 Based on an analysis of the cost report by the Department, the allowable costs will be determined based on the Principles of Reimbursement for Nursing Facilities contained herein.

80.71.3 The occupancy level that will be used in the calculation of the rate will be set at the days included on the pro forma cost report submitted at the time of the conversion or at the 95% occupancy level, whichever is greater.

80.71.4 The case mix index will be determined as stated in Sections 41.2 , 80.3.1, 80.3.2, 80.3.3.2, and 80.3.4.1.

80.71.5 The upper limits for the direct and routine care cost components will be inflated forward to the end of the fiscal year of the proforma cost report submitted as required in Section 80.71.1.

80.71.6 The reimbursement rates set, as stated in Sections 80.71.1 and 80.71.5, will remain in effect for the period of three (3) years from the date that they are set under these Principles. The direct and routine components will be inflated to the current year, subject to the peer group cap. Reimbursement rates and all rate letters will have an effective date of the first day of the subsequent month after the date of the licensure change.

80.71.7 At the conclusion of the three years, the reimbursement rate will be rebased to the fiscal year stated in Sections 41.3.1, 42.1, and 43 or the most recent audited full fiscal year occurring after the conversion of nursing facility beds to residential care beds, whichever is the most current.

80.71.8 Section 80.7 is effective for Nursing Facilities with the effective date of conversion of nursing facility beds to residential care facility beds occurring on or after January 1, 1996.

81 INTERIM AND SUBSEQUENT RATES

81.1 Interim Rate and Subsequent Year Rates. Fifteen days prior to the beginning of the facility's fiscal year, an interim rate will be established by using the fixed cost component of the previous fiscal year and adding to it the inflated routine cost components of the base year. The interim rate in subsequent fiscal years will be determined in the same manner as outlined above. The direct cost component is computed as specified in Section 80.3.4.

81.2 Effective July 1, 2002, fixed costs may be adjusted upon request of the provider when sufficient documentation (determined by the DHS) has been provided to the Department. These adjustments will be effective for the subsequent quarterly calculation of the direct care component.

82 FINAL PROSPECTIVE RATE.

Upon final audit of all nursing facility's base year cost reports, the Department will determine a final prospective rate.

82.1 A cost report is settled if there is no request for reconsideration of the Division of Audits findings made within the required time frame or, if such request for reconsideration was made and the Division of Audit has issued a final revised audit report.

84 FINAL AUDIT OF FIRST AND SUBSEQUENT PROSPECTIVE YEARS.

84.1 Principle. All facilities will be required to submit a cost report in accordance with Section 32 at the end of their fiscal year on cost report forms approved by the Department. The Department will conduct a final audit of each facility's cost report, which may consist of a full scope examination by Department personnel and which will be conducted on an annual basis.

84.2 Upon final audit of a facility's cost report for the first and subsequent prospective years, the Department will:

84.2.1 determine the actual allowable fixed costs incurred by the facility during the cost reporting period,

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84.2.2 determine the occupancy levels of the nursing facility,

84.2.3 determine reimbursable direct care costs incurred by the facility during the reporting period per Section 80.3.5.

84.2.4 Determine the actual allowable routine costs incurred by the facility during the cost reporting period per Section 80.5.6.

84.2.5 Calculate a final rate.

84.2.6 Determine final settlement by calculating the difference between the audited final rate and the interim rate(s) paid to the provider times the Medicaid utilization.

Nursing facilities that transfer a cost center from one cost component to another cost component resulting in increased Medicaid costs will have the affected cost components adjusted at time of audit.

Upon final audit of a facility's cost report, the Department will calculate a final prospective rate and determine the lump sum settlement amounts either due to or from the nursing facility.

The Division of Audit final audit adjustment to the nursing facilities annual cost report will consider the impact of days waiting placement as specified in the Principles of Reimbursement for Residential Care Facilities. Fixed cost reimbursement for the nursing facility will not be affected by days waiting placement reimbursement to the nursing facilities.

85 SETTLEMENT OF FIXED EXPENSES

85.1 The Department will reimburse facilities for the actual allowable fixed costs which are incurred during a fiscal year. Upon final audit of a facility's cost report, if the Department's share of the allowable fixed costs actually incurred by the facility is greater than the amount paid by the Department (the fixed cost component of the final prospective rate multiplied by the number of days of care provided to Medicaid beneficiaries), the difference will be paid to the facility by the Department. If, the Department's appropriate share of the allowable fixed costs actually incurred by a facility is less than the amount paid by the Department, the difference will be paid to the Department by the facility.

85.2 Federal regulations state that during the first year of implementing the nursing home reform requirements, the new costs which a facility must incur to comply with these requirements will be treated as a fixed cost. The facility must maintain the appropriate documentation in order for these costs to be identified at the time of the facility's final audit.

The cost associated with meeting the Nursing Home Reform Act of 1987 requirements will continue to be treated as a fixed cost through the facility's first full fiscal year after September 30, 1991 and will not be included in the determination of incentive payments which the facility might be entitled to receive as a result of its performance during that year. Thereafter, the cost associated with implementing the Nursing Home Reform

Act of 1987 will be considered in the appropriate cost component and will be added to the facility's final prospective rate.

Upon final audit of a facility's cost report, if the Department's share of the allowable OBRA costs actually incurred by the facility is greater than the amount paid by the Department, the Department will pay the facility the difference. If on the other hand, the Department's appropriate share of the allowable OBRA costs actually incurred by a facility is less than the amount paid by the Department, the difference will be paid to the Department by the facility.

86 ESTABLISHMENT OF PEER GROUP

86.1 Establishment of Peer Group. All Nursing care facilities will be included in one of three peer groups. Hospital based nursing facilities (excluding governmental institutions) will comprise one peer group, non-hospital based facilities with sixty or fewer beds with compose a second peer group, and non-hospital based facilities with more than sixty beds will compose the third peer group. Please refer to Appendix C for a description of a hospital based nursing facility. For determining the Medicare upper limit, it should be noted that the establishment of these three peer groups in developing a payment model is not an accepted model in determining the upper limits as established by Federal Statute. The Federal Statute recognizes free standing nursing facilities in determining the upper limit. The upper limit for hospital based facilities is based on one-half the routine costs of freestanding facilities and one-half the costs of hospital based facilities. Therefore, the appropriate Medicare upper limit test will be applied to all nursing facilities.

88 CALCULATION OF OVERPAYMENTS OR UNDERPAYMENTS.

Upon determination of the final rate as outlined in section 84 above, the Department will calculate the net amount of any overpayments or underpayments made to the facility.

If the Department determines that it has underpaid a facility, the Department will estimate the amount due and forward the result to the facility within thirty days. If the Department determines that it has overpaid a facility, the Department will so notify the facility. Facilities will pay the total overpayment within sixty (60) days of the notice of overpayment or request the Department to reduce facility payments during the balance of its fiscal year by the amount of the overpayment. Facilities that do not notify the Department of the method by which they intend to repay the overpayment will, beginning 60 days after their receipt of the notice of overpayment, have their subsequent payments from the Department reduced by the amount of overpayment.

If a facility appeals a determination of overpayment, the facility must repay within sixty (60) days of the notice of overpayment all portions of the determined overpayment except those that are expressly disputed and for which specific dollar values are identified. Repayment of each such specifically disputed portion and identified amount shall be stayed pending resolution of the dispute with respect thereto. The amount of money in dispute must be identified in the manner outlined in Section 150.

The net amount of any over or underpayment made to the facility will be based on 1) the calculation of actual fixed expenses incurred in the prior year and 2) the estimated difference in amount due or paid based on the interim versus final prospective rate.

89 BEDBANKING OF NURSING FACILITY BEDS

89.1 Any bedbanking request must be submitted to the Department for review by the Bureau of Elder and Adult Services and the Bureau of Medical Services. Nursing facilities are permitted to bank nursing facility beds, according to the guidelines contained in Title 22, Section 304, providing the space left vacant in the facility is not used for the creation of private rooms. In addition to those guidelines, a floor plan must be submitted to the Bureau of Elder and Adult Services which describes the intended use of the banked bed spaces. This floor plan will be reviewed by the Department. Reimbursement of costs associated with the banked beds will be allowed to the extent that such costs have been approved by the Department. Reasons that the Department may deny the space as reimbursable under these Principles includes, but is not limited to, the following:

89.11 the use of the space is not reimbursable under the criteria contained in these Principles,

89.12 the proposed purpose of the use of the space has already been designated by other space within the facility and this would constitute duplication of use,

89.13 the proposed use of the space is not deemed to be in the best interest of the physical, emotional, and safety needs of the residents (In this case, a recommendation by the Department may be made for an alternative use of the space).

89.2 Pursuant to Title 22, Section 304, the following cost components shall be decreased by a percentage equal to the percentage of bed days decreased by the banking of the beds. Total bed days used to calculate this percentage will be the audited days (as filed if audited days are not available) from the base year cost report. (e.g. If a facility decreased the number of beds by 25%, and the total bed days in the base year equals 40000 and the facility was at 90% occupancy = 36000 days, then the bed days used in the calculation of the rate after the bedbanking would equal 90% of 30000 days or 27000 days.) This percentage decrease would be used in the calculation of the new rate for the following cost components based on what the total audited costs (as filed, if audited costs are not available) in the base year:

89.21 Routine Cost Component

89.21.1 Administrative and Management Ceiling.
89.21.2 Housekeeping Supplies
89.21.3 Laundry Supplies
89.21.4 Dietary Supplies
89.21.5 Patient Activity Supplies
89.21.6 Food Costs

89.3 Direct Care Cost Component - The Direct Care Cost Component will be decreased, subject to Licensing and Certification Regulations, by a percentage equal to 50% of the total percentage decrease based on the audited costs (as filed, if audited costs are not available) in the base year for the following areas:

89.31 RNs
89.32 LPNs
89.33 CNAs, CMAs
89.34 Contract Nursing
89.35 Payroll Benefits and taxes for 89.31 through 89.34
89.36 Medical Supplies/Medicine and Drugs

(e.g. Using the example in 89.2 of a 25% decrease, if the total audited costs (as filed, if audited costs are not available) of the RNs, LPNs, CNAs, CMAs, Contract Nursing, and benefits and taxes and medical supplies/medicine and drugs were $400,000 in the base year, the allowable costs for this component would be reduced by $50,000 or 12.5%. The ratio of labor costs to benefits and taxes as contained in the base year cost report would be used in the determination of the amounts decreased in each of those areas.) Reimbursement rates and all rate letters will have an effective date of the first day of the subsequent month after the date of the licensure change.

90 DECERTIFICATION/DELICENSING OF NURSING FACILITY BEDS

90.1 Pursuant to Title 22, Section 304, any request for delicensing/decertification of nursing facility beds must be submitted to the Department for review by Bureau of Medical Services. In addition to those guidelines, a floor plan must be submitted to the Bureau of Medical Services which describes the intended use, if any, of the space that the beds previously occupied. This floor plan will be reviewed by the Department. Reasons that the Department may deny the space as reimbursable under these Principles includes, but is not limited to, the following:

90.11 the use of the space is not reimbursable under the criteria contained in these Principles,

90.12 the proposed purpose of the use of the space has already been designated by other space within the facility and this would constitute duplication of use,

90.13 the proposed use of the space is not deemed to be in the best interest of the physical, emotional, and safety needs of the residents (In this case, a recommendation by the Department may be made for an alternative use of the space).

90.2 The following cost components shall be decreased by a percentage equal to the percentage of bed days decreased by the delicensing/decertification of the beds. Total bed days used to calculate this percentage will be the audited days (as filed if audited days are not available) from the base year cost report. The example used in Section 89.2 to also applicable to this section. This percentage decrease would be used in the calculation of the new rate for the following cost components based on what the total audited costs (as filed, if audited costs are not available) in the base year:

90.2 Routine Cost Component

90.21.1 Administrative and Management Ceiling.
90.21.2 Housekeeping Supplies

90.21.3 Laundry Supplies
90.21.4 Dietary Supplies
90.21.5 Patient Activity Supplies
90.21.6 Food Costs

90.3 Direct Care Cost Component - The Direct Care Cost Component will be decreased, subject to Licensing and Certification Regulations, by a percentage equal to 50% of the total percentage decrease based on the audited costs (as filed, if audited costs are not available) in the base year for the following areas:

90.31 RNs
90.32 LPNs
90.33 CNAs, CMAs
90.34 Contract Nursing
90.35 Payroll Benefits and taxes for 90.31 through 90.34.
90.36 Medical Supplies/Medicine and Drugs

(e.g. Using the example in 89.2 of a 25% decrease, if the total audited costs (as filed, if audited costs are not available) of the RNs, LPNs, CNAs, CMAs, Contract Nursing, and benefits and taxes were $400,000 in the base year, the allowable costs for this component would be reduced by $50,000 or 12.5%. The ratio of labor costs to benefits and taxes as contained in the base year cost report would be used in the determination of the amounts decreased in each of those areas.) Reimbursement rates and all rate letters will have an effective date of the first day of the subsequent month after the date of the licensure change.

91 INFLATION ADJUSTMENT – Cost of Living Adjustment (COLA)

The Commissioner of the Department of Human Services will determine on an annual basis if an inflation adjustment will be made, the amount of that adjustment, and any performance standards related to that adjustment.

91.1 Total wages and benefits for front line employees for fiscal years beginning on or after July 1, 2001 will be divided by total worked hours to determine the average wage and benefit rate per hour. This rate per hour will be compared to the prior year wage and benefit rate per hour to determine a percentage change in the rate per hour. If the nursing facility does not demonstrate a minimum equal to the COLA increase in the combined wage and benefit rate per hour for front-line employees, the COLA will be recouped at time of audit. Front-line employees are defined as all employees who work in the facility, except the administrator and contract labor.

92 REGIONS

The regions, for DHS analysis purposes, are:

Region I - Cumberland County, Knox County, Lincoln County, Sagadahoc County, and York County.

Region II - Androscoggin County, Franklin County, Kennebec County, Oxford County, and Somerset County.

Region III - Penobscot County, Piscataquis County, Waldo County, Hancock County, and Washington County.

Region IV - Aroostook County

93 DAYS WAITING PLACEMENT

Reimbursement to nursing facilities for days waiting placement are governed by the regulations specified in the Principles of Reimbursement for Residential Care Facilities.

120 EXTRAORDINARY CIRCUMSTANCE ALLOWANCE

Facilities which experience unforeseen and uncontrollable events during a year which result in unforeseen or uncontrollable increases in expenses may request an adjustment to a prospective rate in the form of an extraordinary circumstance allowance. Extraordinary circumstances include, but are not limited to:

* events of a catastrophic nature (fire, flood, etc.)
* unforeseen increase in minimum wage , Social Security, or employee retirement contribution expenses in lieu of social security expenses
* changes in the number of licensed beds
* changes in licensure or accreditation requirements

If the Department concludes that an extraordinary circumstance existed, an adjustment will be made by the Department in the form of a supplemental allowance.

The Department will determine from the nature of the extraordinary circumstance whether it would have a continuing impact and therefore whether the allowance should be included in the computation of the base rate for the succeeding year.

121 CERTIFICATE OF NEED EXTRAORDINARY CIRCUMSTANCE ALLOWANCE

121.1 Based on findings made by the Commissioner of the Department of Human Services (hereinafter, the Commissioner), the Department may approve extraordinary routine and fixed costs in excess of the provider's approved Certificate of Need (CON) that are within the upper limits established by the Department for the routine component, when all of the following conditions are met:

121.1(a) Costs would ordinarily be allowable under Federal Regulations and these Principles of Reimbursement;

121.1(b) Costs would have been allowable under the CON had a CON amendment been filed within the time constraints as outlined in the CON statutes and approved by the Department;

121.1(c) Approval is necessary in order for the Provider to obtain favorable refinancing, as determined by the Department;

121.1(d) Failure to approve may adversely affect resident care; and

121.1(e) In the Department's judgment, approval will further the Department's goal of ensuring that public funds are only expended for services that are necessary for the well being of the citizens of Maine.

121.2 Department approved costs, as determined in Section 121.2, from the CON will be recognized at the time the Department approves the Certificate of Need Extraordinary Circumstance Allowance for a nursing facility.

121.3 The Department may require that the Provider(s) or owner of the Provider(s) who have been granted a Certificate of Need Extraordinary Circumstance Allowance under these Principles, be subject to the following conditions:

121.3(a) Be managed through an unrelated management company;

121.3(b) Hire a licensed administrator, through an unrelated management company, who is approved by the DHS Division of Licensing and Certification; and

Sections 121.3(a) and 121.3(b) will be in effect for a period of time determined by the Department.

121.4 If the provider fails to obtain the acceptable refinancing described in Section 121 within 15 months of the date the Commissioner made the findings under Section 121.1, the Department may 1) recapture costs approved under Section 121 at time of audit; or 2) withdraw the Extraordinary Circumstance Allowance under Section 121.

130 ADJUSTMENTS

130.1 Adjustment for Unrestricted Grants or Gifts. Unrestricted Federal or State grants or gifts received by a facility and which have been deducted from operating costs for purposes of reimbursement will be added back to the direct resident care and routine cost component for purposes of calculating a base rate.

130.2 Adjustment for Appeal Decisions. The Department will adjust any interim or final prospective rate to reflect appeal decisions made subsequent to the establishment of those rates.

130.3 Adjustments for Capital Costs. The Department will adjust the fixed cost component of an interim or final prospective rate to reflect increases or decreases in capital costs. For example costs which have been approved under the Maine Certificate of Need Act or refinancing.

140 APPEAL PROCEDURES - START UP COSTS - DEFICIENCY RATE - RATE LIMITATION

140.1 Appeal Procedures

140.1.1 A facility may administratively appeal any of the following types of Division of Audit determinations:

1. Audit Adjustment
2. Calculation of final prospective rate
3. Adjustment of final prospective rate or a refusal to make such an adjustment pursuant to these Principles.

140.1.2 An administrative appeal will proceed in the following manner:

1. Within 30 days of receipt of an audit or other appealable determination, the facility must request, in writing, an informal review before the Director of the Division of Audit or his/her designee. The facility must forward, with the request, any and all specific information it has relative to the issues in dispute, note the monetary amount each issue represents and identify the appropriate principle supporting the request. Only issues presented in this manner and timeframe will be considered at an informal review or at a subsequent administrative hearing.

2. The Director or his/her designee shall notify the facility in writing of the decision made as a result of the informal review. If the facility disagrees with the results of the informal review, the facility may request an administrative hearing before the Commissioner or a presiding officer designated by the Commissioner. Only issues presented in the informal review will be considered at the administrative hearing. A request for an administrative hearing must be made, in writing, within 30 days of receipt of the decision made as a result of the informal review.

3. To the extent the Department rules in favor of the facility, the audit report or prospective rate will be corrected.

4. To the extent the Department upholds the original determination of the Division of Audit, review of the results of the administrative hearing is available in conformity with the Administrative Procedures Act, 5 M.R.S.A. §11001 et seq.

152 DEFICIENCY PER DIEM RATE.

When a facility is found not to have provided the quality of service or level of care required, reimbursement will be made on 90% of the provider's per diem rate, unless otherwise specified. This "deficiency rate" will be applied following written notification to the facility of the effective date of the reduced rate for any of the following service deficiencies:

152.1 Staffing over a period of two weeks or more does not meet the Federal Certification and State Licensing requirements, except where there is written documentation of a good faith effort to employ licensed nurses to meet the licensed nurse requirements over and above the full time director of nursing;

152.2 Food service does not meet the Federal Certification and State Licensing requirements;

152.3 Specific, documented evidence that the care provided does not meet the Federal Certification and State Licensing requirements. Such penalty to be effective no sooner than 30 days from written notification that such deficiencies exist;

152.4 Failure to correct, within the time frames of an accepted Plan of Correction, deficiencies in meeting the Federal Certification and State Licensing requirements, which cause a threat to the health and safety of residents in a facility or the surrounding community;

152.5 Failure to submit a cost report, financial statements, and other schedules as requested by the Division of Audit and to maintain auditable records as required by these Principles and other relevant regulations may result in application of the deficiencies per diem rate. The deficiency per diem rate for these items will go into effect immediately upon receipt of written notification from the Department of Human Services.

152.6 Failure to correct MDS as requested in writing and submit within the specified time outlined in Section 41.21 of these Principles of Reimbursement.

A reduction in rate because of deficiencies shall remain in effect until the deficiencies have been corrected, as verified by representatives of the Department of Human Services, following written notification by the provider that the deficiencies no longer exist. No retroactive adjustments to the full rate shall be made for the period that the deficiency rate is in effect unless the provider demonstrates to the satisfaction of the Department that there was no just cause for the reduction in payment.

160 INTENSIVE REHABILITATION NF SERVICES FOR TRAUMATIC BRAIN INJURED INDIVIDUALS (TBI)

It has been determined that the reasonable cost of comprehensive rehabilitative services of traumatic brain injury is an allowable cost. This requires that the facility possess characteristics, both in terms of staffing and physical design, which create a unique unit providing comprehensive rehabilitative TBI services.
The Department will require that the facility obtain prior approval of its staffing pattern for the nursing and clinical staff associated with the TBI unit from the Bureau of Medical Services. This approval becomes the upper limit for settlement purposes. In the event a facility believes that the needs of the residents it serves have increased or decreased, the facility must request prior approval from the Bureau of Medical Services authorizing such a change to its staffing pattern/reimbursement rate.

The Department will recognize a NF-TBI unit when it is a distinct part of a dual-licensed nursing facility. The facility will be reimbursed for the average annual per diem cost for TBI rehabilitative services, subject to the upper limits described herein, for individuals classified as eligible for TBI services in accordance with Chapter

2, Section 67 of the Maine Medical Assistance Manual. There can be no duplication of services with other providers if clinical and therapy services are included in the facility's staffing/reimbursement rate.

160.1 Principle. A nursing facility which has a recognized TBI unit will be reimbursed for services provided to recipients covered under the Title XIX Program based upon the actual cost of services provided, subject to the upper limit. The Department will establish the rate and determine that the cost is reasonable and adequate to be an efficiently and economically operated facility in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards.

160.2 Cost. The Department's payments made for allowable TBI services provided will be based on the actual cost of services provided, subject to the upper limit. The allowable per diem cost for TBI services will include a routine service component and a rehabilitative ancillary service component.

160.2.1 The direct and routine cost component rates, that is, (the direct and routine costs less fixed costs and ancillary service costs) will be increased annually by the rate of inflation at the beginning of a facilities fiscal year. This per diem rate is subject to audit and will be adjusted to actual costs or the upper limit (per Section 160 for the direct care cost), whichever is less, at year-end.

160.2.2 Rehabilitative ancillary services included in the care of a traumatically brain injured individual residing in a recognized TBI unit shall be considered an allowable cost. Covered ancillary services must meet the requirements and definitions under Medicare regulations.

160.3 Rehabilitative ancillary services are not subject to the routine service cost limitations.

Rehabilitative ancillary services include:

- Physical Therapy Services
- Occupational Therapy Services
- Speech Pathology Services
- Respiratory Therapy Services
- Recreational Therapy Services
- Physiatry Evaluation and Consultation Services
- Neuropsychology Evaluation and Consultation Services
- Psychology Evaluation and Consultation Services

160.4 Cost Reporting. Costs will be reported on forms provided by the Department which will segregate NF-TBI routine costs and TBI ancillary costs from standard NF costs.

For the purpose of calculating a separate NF-TBI rate, whether interim or final, a facility that has been granted a special NF-TBI rate for a distinct part shall allocate its costs to the distinct part as if the distinct part were licensed as a separate level of care.

All other principles pertaining to that allowability, recording and reporting of costs shall apply.

171 COMMUNITY-BASED SPECIALTY NURSING FACILITY UNITS

COMMUNITY-BASED SPECIALTY NURSING FACILITY UNITS PROVIDING SERVICES UNDER CONTRACT WITH THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (DMHMRSAS) TO FORMER RESIDENTS OF THE AUGUSTA MENTAL HEALTH INSTITUTE (AMHI) AND THE BANGOR MENTAL HEALTH INSTITUTE (BMHI).

The Department may designate specialty nursing facility units that provide special services under contract with the Department of Mental Health and Mental Retardation and Substance Abuse Services to former residents of the Augusta Mental Health Institute (AMHI) and the Bangor Mental Health Institute. It has been determined that the reasonable cost of services for these residents, who have multiple medical needs that make them eligible for nursing facility level of care and have a primary diagnosis of mental illness that requires the ongoing supervision of trained professionals, is an allowable cost. This requires the nursing facility unit to possess characteristics, both in terms of staffing and physical design, for providing services to these residents.

Such designated specialty units shall be subject to the provision of these rules, except for the rate limitations contained in Sections 80-87.

The Department will require that the facility obtain prior approval of its staffing pattern for the nursing and clinical staff associated with these facilities from the Bureau of Medical Services. In the event a facility believes that the needs of the residents it serves have increased or decreased, the facility must request prior approval from the Bureau of Medial Services authorizing such a change to its staffing pattern.

171.1 Principle. A nursing facility which is recognized as a specialty unit under this section will be reimbursed for services provided to residents covered under the Title XIX program based upon the actual cost of services provided. The Department will establish the rate and determine that the cost is reasonable and adequate to be an efficiently and economically operated facility in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

171.2 Cost. The Department's payments made for allowable services provided will be based on the actual allowable cost of services provided to such residents. The allowable per diem cost for the services will be increased annually by the rate of inflation at the beginning of each facility's fiscal year. This per diem rate is subject to audit and will be adjusted to the actual allowable costs of providing services to such residents in these units at year end.

171.3 Cost Reporting. Costs will be reported in a manner that will segregate the costs of such residents in the specialty unit from the costs of other residents in the unit and the standard nursing facility's costs as apply under these Principles.

For the purpose of calculating the reimbursement rate for such residents in the specialty unit, whether interim or final, a facility that has been designated as a specialty unit under this section of the Principles for a distinct part shall allocate the costs of such residents in the distinct part as if the distinct part were licensed as a separate level of care.

All other sections of theses Principles pertaining to the allowability, recording, and reporting of costs shall apply.

APPENDIX A: DEFINITIONS

The term Department as used throughout these principles is the State of Maine Department of Human Services.

The term State Licensing and Federal Certification as used throughout these principles are the "Regulations Governing the Licensing and Functioning of Nursing Facilities" and the Federal Certification requirements for nursing care facilities that are in effect at the time the cost is incurred.

Accrual method of accounting means that revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

AICPA: American Institute of Certified Public Accountants

Allowable costs are those costs that Medicaid will reimburse under these Principles of Reimbursement and that are below the caps (upper limits).

Ancillary Services: medical items or services identifiable to a specific resident furnished at the direction of a physician and for which charges are customarily made in addition to the per diem charge.

Base Year: A fiscal period for which the allowable costs are the basis for the case mix prospective rate.

Capital Asset: Capital Asset is defined as services, equipment, supplies or purchases which have a value of $500 or greater.

Case Mix Weight: A relative evaluation of the nursing resources used in the care of a given class of residents.

Cash method of accounting means the revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

Common Ownership: Common ownership exists when an individual possesses significant ownership or equity in the provider and the institution or organization serving the provider.

Compensation: Compensation means total benefit provided for the administration and policy-planning services rendered to the provider. It includes:

(a) Fees, salaries, wages, payroll taxes, fringe benefits, contributions to deferred compensation plan, and other increments paid to or for the benefit of, those providing the administration and policy-planning services.
(b) The cost of services provided by the provider to, or for the benefit of, those providing the administration and policy-planning services, including, but not limited to food, lodging, and the use of the provider's vehicles.

Control: Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

Cost finding: the processes of segregating costs by cost centers and allocating indirect cost to determine the cost of services provided.

Days of Care means total number of days of care provided whether or not payment is received and the number of any other days for which payment is made. (Note: Bed held days and discharge days are included only if payment is received for these days.)

Direct Costs: costs which are directly identifiable with a specific activity, service or product of the program.

Discrete Costing: The specific costing methodology that calculates the costs associated with new additions/renovations of nursing facilities. None of the historical basis of costs from the original building are allocated to the addition/renovation.

Donated Asset: an asset acquired without making any payment in the form of cash, property or services.

DRI: Data Resources Institute Incorporated national forecasts of hospital, nursing home, and home health agency market baskets as published by McGraw- Hill.

Experience Modifier: This is the rating number given to nursing facilities based on worker's compensation claims submitted for the previous three years. The lower the rating number, the better the worker's compensation claims ratio.

Fair Market Value: The fair market value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have been communicated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

Fixed Cost: The fixed cost component shall be determined based upon actual allowable costs incurred by an economically and efficiently operated facility.

Free Standing Facility: a facility that is not hospital-affiliated.
Fringe Benefits: shall include payroll taxes, qualified retirement plan contributions, group health, dental, and life insurance's, cafeteria plans and flexible spending plans.

Generally accepted accounting principles means accounting principles approved by the American Institute of Certified Public Accountants. (GAAP): those accounting principles with substantial authoritative support. In order of authority the following documents are considered GAAP: (1) FASB standards and Interpretations, (2) APB Opinions and Interpretations, (3) CAP Accounting Research Bulletins, (4) AICPA Statements of Position, (5) AICPA Industry Accounting and Auditing Guides, (6) FASB technical Bulletins, (7) FASB Concepts statements, (8) AICPA Issues Papers and Practice Bulletins, and other pronouncements of the AICPA or FASB.

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Health Care Financing Administration (HCFA): Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

Historical cost: Historical cost is the cost incurred by the present owner in acquiring the asset. The historical cost shall not exceed the lower of:

* current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase;

* fair market value at the time of the purchase;

* the allowable historical cost of the first owner of record on or after July 18, 1984.

In computing the historical cost the four categories of assets will be evaluated, Land, Building, Equipment and Motor Vehicles. Each category will be evaluated based on the methods listed above.

Hospital-affiliated facility: a facility that is a distinct part of a hospital provider, located within the same building as the hospital unit or licensed as a hospital facility.

Land (non-depreciable): Land (non-depreciable) includes the land owned and used in provider operations. Included in the cost of the land are costs of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider and other land expenditures of a non-depreciable nature.

Land Improvements (depreciable): Depreciable land improvements include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the provider).

Leasehold improvements: Leasehold improvements include betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

MDS as used throughout these Principles means the Minimum Data Set that is currently specified by the Health Care Financing Administration for use by Nursing Facilities.

Necessary and proper costs are those which are for services and items that are essential to provide appropriate resident care and activities at an efficient and economically operated facility. They are costs for services and items which are commonly provided and are commonly accepted as essential for the type of facility in question.

Net Book Value: The net book value of the asset is defined as the depreciable basis used under the program by the asset's last participation owner less the depreciation recognized under the program.